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Instructive District Nursing Association

A REVIEW

By MARY BEARD

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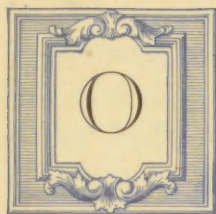
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A REVIEW



OUR Association is now entering on its thirty-sixth year. The population of Boston is 748,060, and during the year 1920 we came into intimate contact with 36,660 patients; this being nearly 10,000 more patients than we had in 1919, an increase unprecedented in any year of our history. To meet this increase of work, 23 nurses were added to the staff, which now numbers 114 salaried nurses and a number of students in the field varying from 15 to 20. About 2,000 has been the usual annual increase in the number of our patients, and this figure represents the yearly increase of most visiting nurse associations in large cities.

Greater usefulness, however, does not always follow more activity, and for this reason, it will be worth while to consider critically what has already been accomplished, in order that we may decide whether or not we are justified in asking for continued and increased support from the people of Boston, and whether there are ways in which our work may be made more effective.

First, we ought to be sure that we are in no respect duplicating the work of other institutions, and that no organization in Boston offers the people service of the same nature as that given by us; in other words, we must be sure that we are not competing with other organizations for community service. We must assure ourselves also that we are

right in emphasizing certain phases of our work, even although such emphasis may sometimes involve the neglect of other needs.

We try to protect and improve the health of the community by helping Boston doctors care for the sick, and, as a part of this work, we try to teach the families into which we are called how to maintain standards of health, and how to prevent sickness.

To attain any degree of success in this effort we are dependent upon constant advice and direction from the Departments of Health of both the State and the City.

The development of our work has been guided, to some extent, by the knowledge that certain kinds of sickness are a greater menace to the public health than are other kinds, and also that, in the interests of future generations, mothers and young babies should be well cared for. For some unexplained reason we are not reaching as many of the adult male population as we ought. About 40 per cent. of all our cases were from the male population, but they were largely among diseases incident to childhood and old age and not among the male industrial population. Because of their greater tendency to sickness, we ought to give special attention to the colored people. They are about twice as susceptible to disease as white people, and therefore we ought to reach proportionately twice as many colored as white persons; whereas, in fact, we do not reach proportionately one-half as many colored as white. This defect in our service should be remedied.

With a view to determining how many persons in Boston needed, but did not receive, our help in 1920, we have compared our figures with statistics of morbidity, which show that about 40 per cent. of the population are sick at some time in any normal year. This includes mothers and babies in maternity cases; acute illness; hopeless chronic cases; in short, all varieties of illness and physical incapacity. Now, in our service, we reached only 5 per cent. of these people; that is, only one in eight. Because many of these eight sick persons were cared for by other community agencies, such as hospitals, institutions for chronic patients, and other nursing agencies, that is, the tuberculosis nurses, and the municipal nurses, we were not needed in all of these cases. Lack of coördination among the agencies for the care of the sick in Boston renders it impossible to know how many cases of sickness which should be cared for are not reached. We do know that the proportion is relatively small. Through the Boston Health League, a new organization, later referred to, we hope in the future for a better coördination of these agencies, which will enable us to determine just what is done by each. Our chief concern now is that we ourselves reach only one-eighth of the whole number of cases of sickness, and that even this is a heavy task.

To nurse the sick in their own homes is our first business, but we must be very clear in our definition of "*nursing the sick*," since this is our primary function.

Public Health Nursing is a much more complex service than that of nursing sick people in hospitals, where patients

are in well-ordered wards or private rooms, with doctors within call and every facility for the care of sickness close at hand; and it is quite unlike private duty nursing, where the patient has the continuous care of one or more nurses. The public health nurse usually spends about an hour in making a visit; an hour in which she not only cares for the patient, but also teaches some member of the family to give the necessary nursing care in her absence. She is responsible for the health of each individual member of the family and will therefore, where it is possible, time her future visits so that she may see each member of the family before her connection with the family comes to an end. In order that her visit may be of the greatest value to the patient, the family, and the community, she must teach the family not only how to give the patient nursing care, but also how to protect themselves, as far as possible, against future ill-health; and what they can do to overcome physical defects already existing. In the communicable diseases of childhood it is of great importance that parents should be taught not only how to care for the patient, but how to protect other members of the family; that they should understand that anti-toxin given, when the disease first develops, to a child with diphtheria may save his life; that it is dangerous to permit well children to associate with sick children; and that an early diagnosis through laboratory tests often results in saving the life. Difficult though it often is to convince the people of these facts, yet mothers, anxious over their sick children, will usually be found responsive to the efforts of

the nurse to help them, and the influence of the woman who comes into the home, rolls up her sleeves, and works hard for an hour, giving bedside care to a patient, is likely to be considerable. Without doubt, her instructions to the mother, as well as her own actual service to the children sick with measles and whooping cough, greatly reduce the number of subsequent cases of pneumonia, bad condition of the eye or ear, and many other preventable sequelæ.

That all this teaching, however, must be skillfully and tactfully done, we can well appreciate when we consider the many races represented by the people of Boston, their standards of living, the possibility of cross infection, and, in general, the unsatisfactory conditions regarding food, cleanliness, and space under which they live.

Our staff nurses have an invaluable opportunity in visits to the young Italian or Jewish mothers, to teach, chiefly by suggestion, American ideals. Table A shows the nationalities of patients in 1920.

TABLE A
NATIONALITIES OF THE PATIENTS NURSED
IN YEAR OF 1920

NATIONALITY	PER CENT. OF TOTAL
American	35.53
Italian	20.50
Irish	17.02
Jewish	8.40
Canadian	5.12
Russian and Polish	3.90
English and Welsh	1.54
Scotch	.74
Swedish	.74
German	.69
French	.21
Other Nationalities	5.00
Unknown	.60

323,772 visits were made and 36,660 patients cared for during the year 1920. For convenience, we have divided our service into three sections.

1. Acute and communicable diseases.
2. Conditions of maternity and infancy.
3. Chronic illness.

Acute and communicable diseases are placed first because they most endanger the health of the community. Conditions of maternity and infancy are treated as next in importance, while chronic illnesses are considered last.

The attitude of the public towards sickness has changed considerably during the past ten years; it now has a better understanding of the problems of public health than it has hitherto had, and it is now more concerned that at least acute illness shall receive proper medical and nursing care.

ACUTE AND COMMUNICABLE DISEASES



SINCE communicable diseases generally are acute, we have classified them together. 58.56 per cent. of all our work in 1920 was with acute or communicable diseases; of which 5.58 per cent. was pneumonia; 6.45 per cent. communicable diseases of children (not including the two principal diseases, scarlet fever and diphtheria); .11 per cent. with typhoid fever cases; and 4.97 per cent. with cases of bronchitis. The care of a typhoid fever patient or of a pneumonia patient makes a very strong appeal to a nurse, because good nursing is so important to the recovery of these patients.

During the year of 1920 we cared for 1,463 pneumonia patients, among whom there were 191 deaths, or 13 per cent. The figure 1,463 includes the number of patients who were sent to hospitals. If we exclude this number and consider only those patients who were cared for throughout their illness in their own homes, we still find a very small percentage of deaths—14 per cent.

In one of our large Boston hospitals during 1920 there were 187 pneumonia patients, with 88 deaths, or about 47 per cent.

Whether or not a pneumonia patient ought to go to a hospital depends chiefly on home conditions. If an intelligent member of the family can give him constant care, he may be better at home than if he is subjected to the strain of removal and of adapting himself to hospital environment. The patient's dread or fear of a hospital is often a determining factor. The great essentials in nursing pneumonia are fresh air and quiet. Space, air, and sunshine, freedom from mental disturbance, regularity of nourishment, are all necessary for a pneumonia patient, and it is surprising how often a resourceful nurse can secure these essentials in unpromising conditions. The nurse, on her first visit to a pneumonia patient, will select the member of the family who seems most teachable, to whom, after careful directions as to the care of the patient and protection of the household, she will intrust the responsibility of the patient throughout his illness. In this way, with the daily or twice daily visits of the nurse, who teaches in every visit, not by word only, but by repeated demonstrations of the simple nursing procedures upon which so much depends, a patient in his own home may be very successfully cared for.

Children constitute a very large part of our pneumonia patients, and where conditions are not too difficult of adjustment, they can, under our supervision, be properly cared for at home.

A mother suffering from pneumonia will often do better at home with her family than in a hospital; though a good deal of effort is often required on the part of the nurse for the satisfactory adjustment of home conditions. Sometimes the nurse must find a relative or a friend of the family who will come and stay in the house during the illness.

There are circumstances, however, under which a pneumonia patient must not stay at home; a typical case is the man living in a lodging house.

Our nurses coöperate with many other agencies to secure convalescent care away from home for their pneumonia patients.

TABLE B
PNEUMONIA CASES
YEAR OF 1920

AGE GROUPS	NO. OF CASES	PER CENT. OF TOTAL	NO. OF DEATHS	CASE FATALITY
TOTAL ALL AGES . . .	1,463	100	191	13
Under 1 year . . .	173	11.8	29	16.7
1 to 2 years . . .	275	18.8	41	14.9
2 to 5 years . . .	269	18.4	15	5.2
5 to 9 years . . .	172	11.8	8	4.6
10 to 15 years . .	41	2.8	2	4.9
TOTAL UNDER 15 YEARS	930	63.6	95	10.2
15 to 45 years . .	302	20.6	33	10.9
45 years and over . .	231	15.8	63	27.2
TOTAL OVER 15 YEARS .	533	36.4	96	18

It will be noted that almost 64 per cent. of these patients were children and that 10 per cent. of them died, whereas among the remaining 36 per cent., who were adults, 18 per cent. of them died. Again separating the groups we find a case fatality of 10.9 per cent. in the 15 to 45 year group, and the highest fatality of all, 27.2 per cent., among the group of 45 years and over.

In typhoid fever cases, nurses do not like to take the responsibility of caring for patients at home, because there are so many ways in which an untrained person may break the technique of nursing, and by so doing carry the living typhoid organism to some other member of the family. Doctor and nurse are generally united in trying to get typhoid fever patients into hospitals. Yet we had, during 1920, 30 typhoid patients and 22 in the first six months of 1921, a larger number than in any other year for several years past.

It is difficult for a person unaccustomed to sickness to realize that washing the hands in the special basin set apart for that purpose every time the patient, or anything that has come in contact with the patient, has been touched, is the only way to be sure that furniture or dishes or food will not be contaminated and become the means of infecting others.

In the communicable diseases of childhood, teaching by demonstration is especially valuable.

Our nurses give bedside care to children with whooping cough, measles, chicken pox, or mumps, and in our many years of caring for these cases, we have never had a cross infection.

Bedside nursing of scarlet fever and diphtheria cases by public health nurses is not provided for by any agency in the city. Though the municipal nurses are expected to visit scarlet fever and diphtheria cases, their duties do not include bedside nursing. That this is a defect in the nursing service of the city which should be remedied as soon as possible is very apparent, and is often shown by incidents in our experience. Not long ago, in a part of the city where there were many cases of diphtheria, we found a mother caring for a child with diphtheria, and, in the intervals of her nursing, selling candy to children in the neighborhood.

One hundred and five cases of diphtheria and scarlet fever, or $2\frac{1}{2}$ per cent. of all diphtheria and scarlet fever cases reported in the city, came to our notice in the course of our regular visiting. We took cultures from suspicious throats whenever we were asked to do so by the doctors, but when the diagnosis of diphtheria or scarlet fever was made, our policy did not permit us to continue with the case.

MATERNITY CASES



WENTY thousand babies were born in 1920 in Boston. An obstetrician who might be asked, "Is it safe to permit maternity patients to be cared for by nurses who are at the same time caring for other patients, doing surgical dressings, giving bedside care to pneumonia patients, or caring for a child with measles?" would reply, "No, it is not safe." Yet this is the method employed, with unquestionable success, throughout Boston. We have never had a case of cross infection, and we have by this method materially reduced the maternal death rate. This statement is based on these facts: The records of the health department show that there were in 1920 seven maternal deaths in every 1,000 births; while in the maternity service of the Instructive District Nursing Association there were, in 1920, two deaths for every 1,000 cases, which means that the lives of 100 Boston mothers would have been saved had they all had this service. These results, moreover, must, we believe, be attributed primarily to the nursing service, which maintains a definite standard, while the medical service necessarily varies with the doctor. Twenty-six per cent. of the maternity service was for the Boston Lying-In Hospital; 3 per cent. for the Jewish Women's Maternity Association; and the remaining 71 per cent. was for private doctors, with widely varying degrees of skill.

If the results had not justified our method of generalized nursing, it might well be questioned whether all the nurses of a large public health nursing staff are capable of giving successful maternity nursing care. The 114 nurses constituting the staff that has achieved the results quoted have had only the usual maternity training in hospitals; yet associations employing special nurses for maternity work have shown no better figures.

When a new nurse is enrolled on the staff, she is taught by the station supervisor our maternity technique, and is carefully directed in its practice. The station supervisors, realizing the importance of scrupulous observance of the established technique, and the value of prenatal nursing care, see to it that in the pressure of community sickness, no detail in this department of our work is overlooked, and that prenatal visits are not neglected. Through staff conferences, frequent opportunity is given for discussion of the maternity service. Emphasis of the importance of routine procedures through daily contact with station supervisors and through general discussion at staff conference tends to keep up a high standard of maternity nursing.

Inasmuch as 23 per cent. of our entire service is maternity work, it may be of interest at this point to review the history of the development of the maternity service.

In 1901, the Boston Lying-In Hospital and the Instructive District Nursing Association formed a plan of coöperation for the care of the out-patients delivered in the Boston Lying-In Hospital service. The obstetrical care given by the

externes of this hospital, who are Harvard Medical School students, has always been of high grade, and from the early days of our connection with the work both the Board and Staff have taken great pride and satisfaction in making the obstetrical nursing of equally high grade. As already mentioned, 26 per cent. of our maternity service is for patients of this hospital.

From 1909 to 1914, Mrs. William Lowell Putnam promoted a demonstration of prenatal nursing care (which was then being undertaken to a limited extent by the District Nursing Association) in Boston, and the influence of her work has undoubtedly played an important part in the extensive development of prenatal nursing by the Instructive District Nursing Association. Prenatal nursing care in Boston reaches, in proportion to the population, more of the mothers who need it than are reached in any other large city in the country; and, so far as we know, there is no other city in which the percentage of mothers who come under care in the early months of pregnancy is so high. It is the early care and constant supervision that insure good results.

Work with the patients of the Jewish Women's Maternity Association, 3 per cent. of our maternity service, is in coöperation with students from Tufts Medical School, who, under excellent supervision, deliver these patients.

The remaining 71 per cent. of our maternity service is, as has been said, with private doctors. About 600 private doctors, nearly all of whom include in their practice maternity

cases, employ our nurses. Their coöperation and good will have an important bearing upon our service. They employ our nurses because they have found the nurses an essential help in their practice; they have learned that the nurses observe the prevailing ethical standards of the profession; that they do not work without a doctor; and that public sentiment favors their employment.

The method of work from the stations (with the exception of the two health centers to be described later) is to assign to each nurse a small area in which she undertakes the care of all the families. She is responsible for prenatal visits, as well as for visits following the birth of a baby, and also for the care of any sickness meantime occurring in the family.

The success of a generalized nursing service is dependent upon good general preparation of the staff nurses, with sufficient supervision to insure attention to special services, even when there is unusual pressure of acute sickness in the community. The supervision must be by experienced public health nurses, whose work must be supplemented by the knowledge of "special" supervisors, and this supervision must constantly emphasize the cardinal principle of public health nursing; namely, that it is only as a successful teacher, whose instruction of the family makes uninterrupted good nursing possible, that her hour at the bedside of a maternity patient, or half hour spent in making a prenatal visit, will produce the best results.

TABLE C
 PRENATAL AND POSTNATAL WORK
 YEAR OF 1920

PRENATAL

Prenatal Cases . .	4,353	Prenatal Visits . .	28,031
26 per cent. of cases reported before 5th month			
40 per cent. of cases reported before 6th month			
Number of cases followed to conclusion . .			
4,036			
Postnatal care given to 2,834, or 70 per cent.			
Infant mortality (under 2 weeks) . .			
13.37 per 1,000 live births			
Still-births . .			
35.18 per 1,000 births			

POSTNATAL

Postnatal cases, no prenatal care	1,713
Infant mortality (under 2 weeks) . .	
21.01 per 1,000 live births	
Still-births . .	
39.11 per 1,000 births	
City of Boston, Infant Mortality under 2 weeks . .	37.34 per 1,000
live births	

There was an increase of 45 per cent. in the number of our prenatal patients this past year and an increase of 57 per cent. in the number of visits made to them. The greater increase in the visits seems accounted for by the fact that more patients came to us early in their pregnancy.

The infant mortality among these cases shows the same remarkable decrease over the city rates as in former years,

that decrease which the yearly study of results has taught us to expect from prenatal work.

The still-births, however, instead of the usual decrease, showed an alarmingly higher rate than in other years—a rate almost as high as that of the cases where no prenatal care was given. The one curious fact about this increase is that it was among the 30 per cent. of cases to whom we gave care during the prenatal period only, care at and after delivery being given in hospitals and by private nurses, attendants, midwives, and the family. Among the 70 per cent. to whom we gave care during prenatal and postnatal period also, the still-birth rate was even lower than last year.

1,713 cases came to us after they had been delivered, patients who had not had prenatal care from any source. In the last two years there had been a startling difference in the infant mortality and still-birth rates between this group and the group that had prenatal care, this group having rates almost as high as those of the city. This year the infant mortality rate is much less than last year, and less than the city rate.

We may attribute the development of our maternity service to several factors: coöperation with other agencies; the emphasis placed long ago by Mrs. William Lowell Putnam upon prenatal care; the extension of the confidence of the people in our work, of which we have evidence in the constant increase in the number of maternity cases coming from private physicians. In part, it has been due to intentional emphasis of the maternity service as one of the more

important functions of our Association; and in part it has been the result of circumstances. In the future development of the Association, this department will be recognized as deserving a very considerable part of the working time of the staff. An extension of the service to cover the period of confinement should be undertaken for the wards of the city not already provided for; and because without this extension lives are being lost, this should be carried out as soon as possible.

CHRONIC ILLNESS



THOUGH the care of chronic patients is considered of less importance to the public health than the care of other patients, yet there is much to be said in defence of giving a good deal of time to the care of chronic patients. In the first place, our success in improving community health is dependent, to some extent at least, upon our popularity in any neighborhood. Neither patients nor doctors will want us if we refuse to render them the service they need, and that they know we are able to give. The problem of a bed-ridden paralytic may seem to concern only the patient, or only the patient and his family; yet to the neighbors it may appear to be the duty of a public health nurse to spend a good deal of time with that patient. With the human need apparent, and the sympathy of the community aroused, it would be a short-sighted policy that

forbade the Nursing Association to care for that patient, even although life was not actually at stake.

The nurse, on her first visit to a chronic patient, tries to determine just what are his daily needs; whether or not he might be better cared for in some place other than his home; or what effect the illness, with its consequent upsetting of the household, is having, and is likely to have as time goes on, upon other members of the family. She uses all her resources in devising a plan which will best serve the interests of all. In many cases, some member of the family can readily learn to give the care needed for the comfort of the patient, and in such cases it will be necessary for the nurse to give only such time as is needed to teach the "home nurse." In other cases, however, where the family burden is too great, the entire care of a chronic helpless patient should not be left to them, and then, if a "household nurse" cannot be provided; if removal to an institution is not indicated, and if no relative or friend can be found to assume the unusual household cares, the public health nurse must take some responsibility for the actual care and relief of this unproductive case, though it probably can never be improved or cured. This course will best serve the cause she has at heart; for in meeting the need so plainly within her power to relieve, she will win new friends for her work; while, through her relations with the family and the neighbors, she will find many opportunities for constructive health work which otherwise might not have been discovered. Chronic patients will be a part of community health work, so long as sympathy is an

essential characteristic of a good nurse. We must, however, keep in mind that work with these patients is less productive of results than work in other directions.

During the past few years occupational therapy has produced remarkable results with many patients who, without it, would have remained in the chronic, unproductive group. Through the very generous coöperation of the School for Occupational Therapy, 20 of our chronic patients have been given the occupational training which is so valuable as a curative measure.

Though in all our services we emphasize teaching in the home, yet we do not thrust ourselves into the home to teach what is not desired. A public health nurse, trained to observe, to make a tactful approach, to establish friendly relations, and to make her visit profitable as a teaching demonstration, will make health teaching in homes unobtrusive and acceptable. Health teaching, which is preventive work, is a by-product of the nursing visit which calls for no apology, and is made in response to an invitation, and this by-product is often of greater importance than the bedside nursing itself.

In connection with this subject of preventive work, it is of interest that in 177 cases of correctible defects which were under our care from January to June, 1921, we were successful with 51 per cent.

Although a study of these cases shows a large percentage, 49 per cent. of uncoöperative families, when we consider that such serious conditions as diseased hearts and infected joints

may result from infected and hypertrophied tonsils and adenoids, alone, we seem justified in this effort.

If by paying six visits to a patient, we can save even 51 per cent. from the serious consequences of neglect, particularly when we realize that the patients were almost all of them children, we have made good use of our time.

Undoubtedly the nurses carried the responsibility in these families for too long a period and the study has shown us that we must make an arbitrary ruling about preventive visits. For instance, it is now a rule in each station that six visits may be made to a patient where a physical defect needs correction, but that these visits must be made in six successive weeks; that after this period constant visits for the purpose of persuading the mother will not be productive of good results.

We have already reported that in 1920 we had a total of 36,660 patients, as compared with a total of 26,789 in 1919. This represents an increase of 9,871, or 37 per cent. over the previous year. There were 31,877 new patients in 1920, while in 1919 the new patients numbered 23,582. The whole number of visits in 1920 was 323,772, as compared with 247,268 in 1919. The total expenditures for 1920 were \$215,742; in 1919, the total expenditures were \$151,342.

Table D indicates the principal diseases or conditions and the distribution of visits. Only 10 diseases or conditions have been studied in regard to the number of visits paid, the selection being based on those requiring a large number of visits or for some other reason important in our service.

TABLE D
PRINCIPAL DISEASES AND CONDITIONS OF PATIENTS
CARED FOR AND DISCHARGED IN YEAR OF 1920

CLASS OF SERVICE	No. OF CASES		PER CENT. OF TOTAL CASES
Total number of cases discharged (not including 4,858 new-born babies)	26,233		100
I. Acute and Communicable Diseases	15,359		58.56
II. Chronic Diseases	2,811		10.70
III. Puerperal State and Well Babies	7,976		30.4
IV. Not found or not requiring nursing care	87		.34

DISEASE OR CONDITION	No. OF CASES	PER CENT. OF TOTAL CASES	No. OF VISITS	AVERAGE VISIT PER CASE
GROUP I				
Typhoid Fever	30	.11	312	10
* 4 Communicable Diseases of Childhood	1,797	6.85	10,516	5.8
Scarlet Fever and Diphtheria	105	.4		
Influenza	2,307	8.79	13,250	5.7
Diseases of Eye and Ear	547	2.08		
Bronchitis	1,303	4.97	8,528	6.5
Pneumonia	1,463	5.58	14,507	9.9
All other Respiratory Diseases	833	3.17		
Tonsillitis	1,151	4.39	6,040	5.2
Diseases of Digestive System	1,673	6.38		
Acute Diseases of the Genito-Urinary Sys.	321	1.22		
Diseases of Skin and Cellular Tissue	811	3.13		
Burns, Fractures, Sprains, Wounds, and other External Causes	946	3.6		
Encephalitis Lethargica	2			
All other Acute and Communicable Diseases	2,070	7.89		
GROUP II				
Tuberculosis	230	.88		
Cancer	257	.98	7,047	27.4
Rheumatism	282	1.07		
Rickets	78	.3		
Cerebral Hemorrhage, Apoplexy, Paralysis	260	1.	4,533	17.4
Chronic Diseases of Nervous System	288	1.09		
Diseases of Heart	325	1.23	3,419	10.5
Diseases of Veins	152	.58		
Other Diseases of Circulatory System	228	.87		
Chronic Diseases of Genito-Urinary Sys.	325	1.23		
All other Chronic Diseases	386	1.47		
GROUP III				
Pregnancy (with and without after-care)	4,353	23.12	64,447	
Maternity (without prenatal care)	1,713			
Other Diseases and Conditions of Puerperal State	545	2.08		
Well Babies	1,365	5.2		
GROUP IV				
Not found or not requiring care	87	.34		

* Includes measles, whooping cough, chicken pox, and mumps.

The simple division of the cases into groups as shown in Table D leaves much to be desired, since it is impossible to differentiate the diseases in many instances. For example, a case of rheumatism, though usually chronic in character, often becomes acute; while cases of maternity frequently develop complications, which place them in the "acute" group, such as septicemia or albuminuric convulsions. Yet, in spite of these limitations, this classification into three categories serves a purpose in that it indicates the character of our service, and shows the place of emphasis.

An average of less than 10 visits to a pneumonia patient will be noted. This appears to be few visits to this type of disease, but the figure is based on all the cases, including those who were nursed for a short time and then transferred to hospitals, and the patients who had partial home care under our supervision. Actually, a number of cases had twice as many visits as the average.

The average of 27 visits for a cancer patient will also appear low; this figure is affected in the same way as the pneumonia figure. It does not mean that the 27 visits were made in 27 consecutive days; in many instances it is not necessary to see these patients daily, and while many of them remain under our care for months, the nurse is often able to train some member of the family to give sufficient care to lengthen the interval between her visits.

Since colored people are twice as susceptible to illness as are white people, it should be our aim to reach twice as many colored people in proportion to the total colored population

as of the white, and in fact we did not reach one-half as many. We recognize this as a weak point which must be strengthened.

TABLE E
SHOWING NUMBER AND PROPORTION OF PATIENTS BY COLOR
YEAR OF 1920

	NO. OF PATIENTS	PER CENT. OF ALL PATIENTS	PER CENT. OF COLORED POP.	PER CENT. OF WHITE POP.
TOTAL PATIENTS	31,191	100		
Colored . .	305	1	1.9	
White . . .	30,786	99		4.2

Colored people form about 2 per cent. of population of Boston.

HEALTH CENTERS



HEALTH centers were established at Brighton and Hyde Park for the purpose of demonstrating that a continuous nursing service could be successfully given by one nurse, instead of breaking the continuity of the home teaching by introducing a special nurse for the care of babies registered at a "well baby clinic." In Boston, the Baby Hygiene Association provides for this special type of nursing care of babies and young children. The work of the Baby Hygiene Association, however, has not been extended to Hyde Park and Brighton. From these two health centers, with their generalized nursing service, we are able to reach many more homes than we do in other sections of Boston. In the city as a whole we serve 4.9 per cent. of the population, while in Hyde Park we serve 17.1 per cent., or, proportionally, about four times as many. This is because continuity of service is preserved from the health center, while it is frequently broken in those cases where other nurses enter the homes for special services.

A gift of \$3,300 from the Metropolitan Chapter of the Red Cross has made it possible to institute certain new services in Hyde Park. This money has now been spent, and more funds must be obtained for a continuance of the work. The new departments of service are: nursing at the time of confinement, hourly nursing, and a child health clinic, which

admits children from two to fourteen years of age. The departments, together with those already established, make a rounded-out service, which includes prenatal nursing care, service at the time of confinement, bedside care for the mother after the baby's birth, visits to the home under the direction of a pediatrician at the baby health clinic, where children from birth to two years of age are admitted; home visits to children enrolled in the child health clinic; attendance at the dental clinic held twice a week at the health center; and general bedside nursing as in other stations.

The Hyde Park local committee has been of great assistance in enlisting the interest of the community, and its efforts have greatly increased the number of Hyde Park people who apply for our service. To meet the needs in Hyde Park, with a population of 23,849, there are eleven nurses; one dentist who spends two days a week in the center; a doctor in charge of the clinics (4 hours weekly) and his assistant (4 hours weekly).

The entire service in Hyde Park during 1920 cared for 4,413 cases, making 37,410 visits, at a cost of \$19,277.78.

Work with mothers and babies in Hyde Park has shown satisfactory results. In the prenatal service there was no death; the death rate in babies under one year of age was 16 per one thousand, and the death rate in infants in the first two weeks of life was 9.8 per one thousand; while in the city of Boston, as a whole, the death rate in babies less than two weeks' old was 37 per one thousand, and in babies under one year of age, 101 per one thousand.

TABLE F
HYDE PARK HEALTH CENTER
YEAR OF 1920

Population	23,849	
STAFF		
Nurses	11	
* Dentist, 3 times a week		
* Physician, 2 hours a week		
ENTIRE SERVICE	4,413 cases (4,083 patients)	37,410 visits
	NO. OF CASES	PERCENTAGE OF TOTAL
Sick Patients	1,447	33
Prenatal Patients	402	9
Maternity Patients (166 were prenatal also)	210	5
Well Babies, under 2 years	1,260	28
Well Children, 2 to 6 years (164 were also well babies)	424	10
Dental	670	15
Treatments and Advisory Visits to		
Peerless Knitting Mills	1,587	
Well Baby Conferences	48	
Dental Clinics	104	
Deliveries Attended	42	
TOTAL COST, \$19,277.78		
WELL BABY WORK.	Baby death rate, 16 per 1,000 infants under 1 year	
PRENATAL WORK.	No maternal death	
	Infant deaths under 2 weeks, rate 9.8 per 1,000	

* At present 1 dentist 2 days a week for 7 hours
2 physicians 4 times a week

As may be seen from the table marked F, 33 per cent. of the Hyde Park service was with sick patients; 9 per cent. with prenatal patients; 28 per cent. with well babies under two years of age; 10 per cent. with well children between two and six years of age.

It may be of interest to consider briefly the work with well babies at Hyde Park and Brighton. Perhaps the most encouraging feature of this work is the remarkable decline in the death rate of the babies in the six months' period from January to July, 1921. During that time, out of 1,137 babies registered at the clinics, there were but four deaths, or 3.5 in one thousand. These four deaths were due to pneumonia, bronchitis, premature birth, and malformation of the tongue, respectively.

Comparison of our work in 1921 with that covering the same period in 1920 shows an increase of 20 per cent. in the number of babies registered in the clinics.

From the Hyde Park center, in pursuance of our generalized nursing plan, treatments and advisory visits to the number of 1,587 were given in the Peerless Knitting Mills.

The Boston Dispensary, with whose staff we made official connection in January, 1921, whereby we may have, whenever desired, the medical direction of the chief of any service, for our work throughout the city, has been of great assistance in the development of our pediatric work at Hyde Park. The pediatrician who works in our Hyde Park clinic is appointed on the recommendation of Dr. Maynard Ladd, chief of the children's service at the Dispensary.

In January, 1921, we presented to the Norfolk Medical Association a report of our work at the Hyde Park health center, and were glad to receive from that Association formal indorsement of that work.

BUDGET

Turning now to the budget, let us see where the \$215,742 spent in 1920 came from:

SUBSCRIPTIONS	Subscriptions	\$66,322.25
DONATIONS	Local Committees	17,907.64
OR	Permanent Charity Fund.....	8,490.00
GIFTS	Metropolitan Chapter, American Red Cross	847.98
	Total	\$93,567.87
EARNINGS	Metropolitan Life Ins. Co.....	\$34,115.35
	Fees	28,484.04
	Other Nursing Service.....	630.74
	Total	\$63,230.13
INCOME FROM INVESTMENTS.....		\$16,734.54
SIMMONS SCHOLARSHIPS		3,543.60
BOARD AND LODGING OF STUDENTS.....		7,443.72
SUNDRIES		67.04
	Total	\$184,586.90
Balance		23,005.19
		\$207,592.09
Deficit		8,150.01
Grand total		\$215,742.10

The deficit of \$8,000 was eliminated by an unexpected gift before the close of the year.

Unlike many other community activities, the District Nursing Association earns a large sum of money each year. In 1920, it collected in fees from patients \$28,484.04; in payments for visits from the Metropolitan Life Insurance Company, \$34,115.35; \$62,599.39 in all, or 29 per cent. of the total sum of \$215,742 expended.

We believe not only that district nursing should be wholly supported by the community in which it is undertaken, but that it is possible to obtain such support. The service, when well understood, commends itself to any community, as has often been shown in the immediate increase in the number of calls made for nurses when a new station is opened, a doubling of the work, generally, within six months' time. Further development of our organization, however, is necessary in order to secure full community support. We are frequently brought into contact with families who do not know how the Association is maintained; in fact, there seems to be a somewhat general misapprehension that the Association is endowed, or has unlimited resources.

Last year, local committees formed for the purpose of raising money collected \$17,577.64, or 8.1 per cent. of our whole budget. We now have a local committee in connection with 12 of our 14 stations; the whole number of persons acting on these committees is 120. These committees should be enlarged greatly to cover the territory we are serving. In nearly every neighborhood of Boston, there is now a dis-

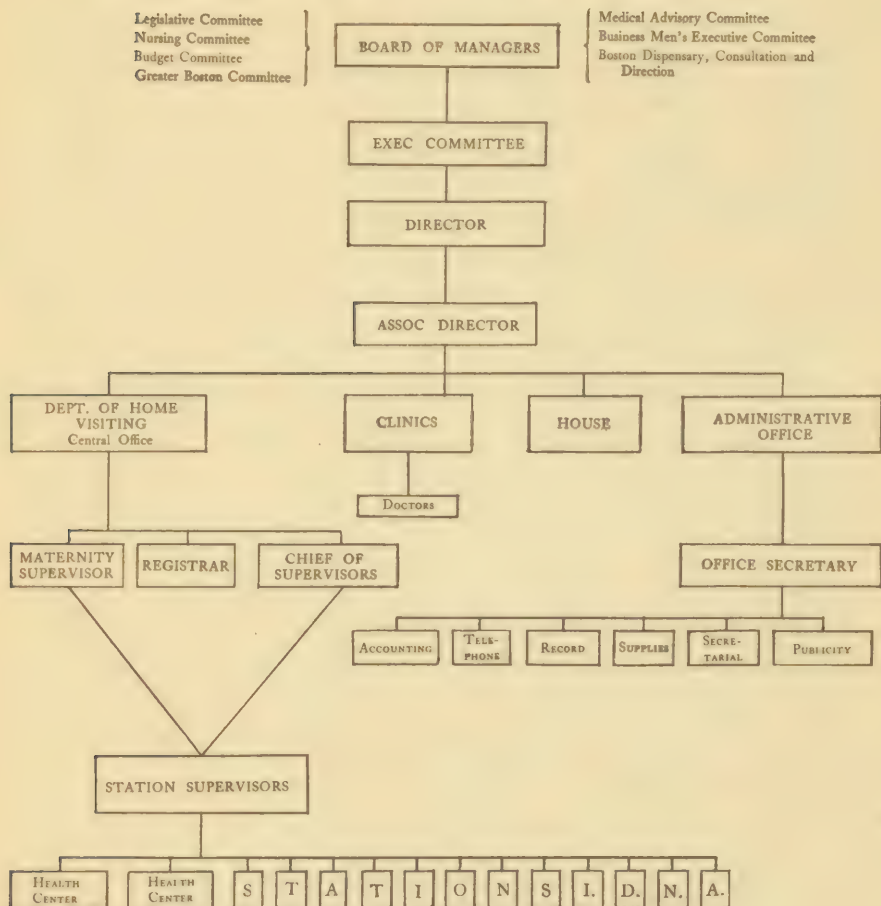
trict nurse who responds to all calls coming from that neighborhood. Each nurse should have a committee of five or more persons, who should undertake to see that every household in that neighborhood is made familiar with the work of the Association and its need of funds; that they are informed that, instead of having money flowing freely into its treasury, it is only through very hard work that it secures money enough to carry on the work already undertaken; and that, because it has been impossible to raise the \$30,000 necessary for the purpose, it cannot extend its maternity service—a service which has proved its usefulness and possibilities of life saving during the past year—throughout Boston, as it ought to do.

A community service which is so generally called upon by so varied a group of citizens ought to be supported by a much more generally representative group than our list of subscribers shows.

In 1916-17 occurred the terrible epidemic of infantile paralysis, as a result of which many Boston children became crippled. The nurses of our Association, working under the Harvard Commission for the after-care of infantile paralysis, carried through a very satisfactory piece of work. It will be remembered that four of the supervisors of the Association were given special training in the after-care of infantile paralysis, and that these nurses then undertook the continuous care of 177 crippled children, with the result that 128 have been restored to the community. In 1920, we had another epidemic of infantile paralysis, adding 72

cripples to our list. To continue this after-care work, and maintain its high quality, it became necessary to train other nurses of the staff in this special type of nursing. This involved the expenditure of more money at a time when some \$20,000—which we saw no means of raising—was already needed to complete the regular work of the year. Reluctantly the Board decided that, unless some then unforeseen means of raising money could be found, we could not go on with the thorough and efficient methods adopted, but must carry on the work as well as we could with an insufficient force. At this point, a member of the committee made an appeal to the postal employees of the city of Boston. The immediate response was touching. The men were grateful for the opportunity to help; and while the sum given by each was small, the total result was a continuance of the work. The sum raised covered the cost of the special education given the nurses, and formed the nucleus of a small special fund to be known as the “postal employees’ fund” for the after-care of infantile paralysis patients. This experience is cited because it seems to show that many people in Boston would welcome an opportunity to help in a work that is of so great benefit to the whole city. Our effort should be to enlist the interest of the whole people, rich and poor, who shall not only support the work, but shall have a voice in the control of its policies. In this way only can we expect to see public health nursing reach its widest usefulness.

INSTRUCTIVE DISTRICT NURSING ASSOCIATION



ORGANIZATION



THE District Nursing Association came into being thirty-six years ago. Its governing Board during those years has been composed almost entirely of women; even today the treasurer is the only man on the Board.

While the devoted and competent women who have built up and directed the organization throughout its history were adequate to the work in its earlier days, and while with remarkable vision they have seen the wisdom of each progressive step that has led to the present volume of work, and with rare courage and ability they have secured the money necessary to such progress, the time has come when the appointment of a more representative Board, made up of both men and women, is imperative. Our Association is the oldest of its kind in the country, and is more fully developed than many public health nursing organizations. It reaches a larger proportion of the population in the territory which it serves than does any other organization of its kind in any large city. But its development has been one-sided, in that its growth on the professional side has, in some measure at least, kept pace with the increasing demands of the community, while there has been little change in the organization of its Board.

As a first step in remedying this defect, and bringing the form of the organization more up to date, a men's executive

committee, consisting of nine members, has been formed. This committee and members of the executive committee of the Board, with the director of the Association, hold meetings for the discussion of the more important affairs of the Association. From this committee, a special committee on legislation, another on policy, and another on budget have been chosen by the chairman, Mr. James J. Phelan. These special committees consult with, and make recommendations to, the corresponding committees of the whole Board. This arrangement, which is recognized by all as clumsy and imperfect, and as only provisional, is yet a step in the right direction, while we wait for the development of the new organization, of which we are a part, and which we hope is to coördinate the functions of all organizations in the city doing work similar to ours. We refer to the Boston Health League.

BOSTON HEALTH LEAGUE



IN the large cities of America, there are many well-established health agencies, each having its own office, board of directors, executive officers, and yearly budget, which each agency raises by means of an appeal to the public. In Boston, with its 29 public health agencies and its population of 748,060, there are many such agencies which are quite unofficial in character, and bear no formal relation to constituted health authority as represented by the Department of Health of the city of Boston. Because they lack central control, and are quite independent of each other in regard to their power to adopt policies, these organizations, formed for the purpose of protecting the health of the family in some special direction (such as the prevention or cure of tuberculosis, the control of cancer, the control of the infant death rate), fall far short of the degree of success which they might achieve. The public health nursing agencies of Boston are typical of the waste of effort due to this situation. The principles of the prevention of sickness can be effectively upheld in a community only through the work of public health nurses. Yet public health nursing in Boston is directed by five unrelated boards, no two of which maintain the same standards, despite the fact that the standards established by the National Organization for Public Health Nursing have been universally indorsed. Though

the nurses of these five organizations coöperate well, their work is not coördinated, as it would be were it directed by a central council. For example, when a mother who has been visited for prenatal care by the nurses of the Instructive District Nursing Association is discharged, the new-born baby is automatically referred to the nurses of the Baby Hygiene Association, who direct the mother in the care of the baby. Automatically also, according to the policy of the Baby Hygiene Association, if this well baby should become ill, he is referred back again to the District Nursing Association until he is well, when he is again returned to the Baby Hygiene nurse. If during the visits of the Baby Hygiene nurse to the mother, the mother again becomes pregnant, she is automatically referred back to the District Nursing Association. This method of administering public health nursing is clumsy, and might be made much more effective if the work of all the nurses were directed by a central council. Were public health nursing under central control, it might be so developed as to meet 100 per cent. of the needs of the community. Under our present unrelated plans of administering public health nursing in Boston, it is almost inevitable that we should each think more of our own development than of one health nursing service which should meet the needs of the community.

Activities essential to all health agencies in Boston are educational propaganda, carried on by means of the dissemination of popular literature in different languages; newspaper publicity; and films and slides for moving picture

houses. Each agency, as has already been suggested, needs a local committee in every neighborhood, in order that the people living there may share in the responsibility for the successes or failures of the work.

No doubt much of the health work now being done in Boston and other large cities by unofficial organizations should be paid for by public funds. In many cities of this country, visiting nurse associations have initiated and established the various public health nursing specialties, such as tuberculosis nursing, school nursing, child welfare nursing; and when the work was well established have turned it over to the city Department of Health. Theoretically, this is as it should be; unfortunately, local government in this country is not maintained at a uniform standard of efficiency, but varies greatly with the officers elected and appointed from time to time. The consequent detriment to health work is very apparent in most cities.

Now, the Boston Health League has, as one of its first objects, the establishment of a strong united body which may become a support to the Department of Health, and which will be in a position, because representative of all the unofficial health agencies, to make, if occasion arises, an appeal to the mayor and city council. Membership in this League is limited to health organizations in Boston proper.

The call for the first meeting to consider the formation of a health league was signed by Dr. William C. Woodward, City Commissioner of Health; Dr. David Edsall, Dean of the Harvard Medical School; the late Mr. Henry B. Endi-

cott, who was formerly chairman of the Massachusetts Committee on Public Safety, and Mr. James Jackson, then chairman of the New England Division of the Red Cross, and was issued to twenty-nine health agencies each of whom was invited to send its president and its chief executive. The agencies invited had each assumed responsibility for some phase of community health work in Boston, and each was invited irrespective of whether it was a national, state, or local agency.

Dr. William C. Woodward was chosen President of the League; the Rev. Michael J. Scanlan, Vice-President; Mrs. Charles Davenport (since deceased), Secretary; Mr. James Jackson, Treasurer; and Dr. Robert B. Osgood, Chairman of the Executive Committee.

The purposes and tentative plans of the League are set forth in a circular letter, prepared by the Executive Secretary, and sent to each of the constituent agencies. We insert a copy of the letter:

“CIRCULAR OF INFORMATION

“In June, 1919, a conference of all of the agencies actively engaged in the protection and promotion of health in the city of Boston was called to consider means whereby the work of such agencies could be correlated, with a view to the promotion of economy and efficiency, both of money and of effort.

“As a result of this meeting and of a preliminary survey

of health activities in one of the districts of the city, a working agreement was drafted for a Health League.

“This agreement states:

“1. The purpose of the Health League is to improve the health of the community.

“2. The means by which this purpose is to be accomplished is through the better coöperation and coördination of the work of the existing agencies, and the further development of a health program.

“The plan of work contemplates the selection of a district in the city, and the opening of headquarters in this district, to act as a center for health information, and for the coördination of all health work in the district.

“A special study will be made of the work of the existing public health agencies in the district in relation to the common health needs, and it is desired by this means to lay the foundation for a more rational health program in the city. Community desire for better health in the district will be supported and encouraged from the center established by the League.

“Nineteen agencies have signed the working agreement at this time:

“Baby Hygiene Association

“Boston Consumptives’ Hospital Trustees

“Boston Dispensary

“Boston Public Schools, Department of Medical Inspection

“Boston Metropolitan Chapter, American Red Cross

“Boston Floating Hospital

- "Children's Hospital, Social Service Department
- "Dietetic Bureau
- "Hawthorne Club
- "Household Nursing Association
- "Instructive District Nursing Association
- "Jewish Maternity Clinic Association
- "Massachusetts General Hospital, Social Service Department
- "Massachusetts Homeopathic Hospital, Social Service Department
- "Massachusetts Society for Social Hygiene
- "Maverick Dispensary
- "Peter Bent Brigham Hospital
- "State of Massachusetts, Department of Health
- "Women's Municipal League, Public Health Department.

"On March 21, 1921, an executive was appointed, and a temporary office has been secured, pending the selection of a district."

East Boston has been chosen as the district in which the demonstration will be made, and the office of the Executive Secretary has been removed to East Boston.

The working agreement, which has been signed by the constituent agencies of the Boston Health League, gives the voting power of each agency to one person selected by that agency. No policies are adopted except at meetings of these representatives. The executive committee has power to carry on the detailed work of the League, but has no power to vote a change of policy. Under this arrangement, an

agency such as the Instructive District Nursing Association, spending a very large sum of money for community health in Boston, has no more power in controlling the policy of the Health League than has an agency spending a very small sum of money, but whose function is necessary to the health of Boston families. To safeguard this arrangement, it is stated that at the regular monthly meeting of the Boston Health League, all members of the boards of constituent agencies are welcome, and may take part in all discussions. It is believed that this will result in bringing before the representatives of other health agencies that knowledge of nursing methods and results which the board of a nursing association has, and that the discussion brought out before votes are taken on nursing policies will influence the vote. Through this pooling of knowledge, we also look to a wider influence on public opinion.

Since the beginning of this movement, it has been the hope of those interested that the neighborhood committees would take an active part in the formation of policies concerning the work of the Health League in their community.



OUR nurses belong, in a very vital sense, to the communities they serve. To them we owe the good reputation which our Association now has, and we cannot express too strongly our admiration for the quality of their work, and the spirit in which it is rendered. They are the mediators, so to speak, between the people whom they serve and our governing Board. To the Board they report the needs of their different communities, which the Board must in turn report and interpret to the whole community. The infantile paralysis work, the extension of the maternity service, the opening of new centers—all our activities—are dependent on the continued coöperation of the Board and the Staff, as well as on the financial and moral support of the people. Since we offer a service needed by all, available to all, and productive of good to all, we should have the active support of all; so that, great as the united efforts of Board and Staff have made the work of the past, we may be enabled to complete what has been begun and extend our service to all the people who need it.



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